

Signature of disabled person

MASSACHUSETTS REGISTRY OF MOTOR VEHICLES

Medical Affairs Branch P.O. Box 199100 Boston, MA 02119-9100 (617) 351-9222



For Hand Deliveries: 630 Washington St., Boston, MA www.mass.gov/rmv

APPLICATION FOR DISABLED PARKING PLACARD/PLATE

THIS SIDE OF THE APPLICATION MUST BE COMPLETED IN THE DISABLED PERSON'S NAME

Disabled person must be a Massachusetts resident. Please note the information required in this application may affect your license status.

NOTE: Incomplete applications will not be processed. This application must be submitted to the RMV within thirty (30) days of the healthcare provider=s certification. You should allow at least thirty (30) days for RMV processing. Additional documentation may be required.

NOTE: REPORT OF CERTAIN MEDICAL CONDITIONS MAY RESULT IN AUTOMATIC LOSS OF LICENSE

Last Name Address Date of Birth		First Name	Middle	Gender
		City/Town	Zip Code Height	Telephone Number
		Social Security Number (SSN)		
Drivers 1	License Number or M	ass I.D. Number		
	•	you have submitted an application for a disabled print your current disabled parking placard or p		No
I am a	pplying for the	e Following:		
	Placard	No fee required for a placard (disabled person-	s photo must be stored be	fore a placard can be issued).
	Plate	Only issued to individuals who have a vehicle registered in his/her name. Registration fees apply.		
	Motorcycle Plate	Only issued to individuals who have a vehicle registered in his/her name. Registration fees apply.		
	DV Plate	Only issued to individuals who a) have a vehicle registered in their name; b) meet Medical Affairs guidelines; c) provide the DV Plate letter from the Veterans Administration stating that the disability is at least 80% service connected.		
AUT	HORIZATIO	ON TO RELEASE MEDICAL RECORDS		
	•	ne healthcare provider completing this form to dispresentatives of the Registry of Motor Vehicles.	cuss and release any or al	I medical records pertaining to it

Date

TO BE COMPLETED BY HEALTH CARE PROVIDER

CLINICAL DIAGNOSIS:	(Required)
DURATION (circle one): Temporary If temporary, please state # of months	Permanent S
PLEASE CHECK ALL THAT APPLY:	
Unable to walk 200 feet without assista	ance (clinical diagnosis MUST be completed)
Legally Blind* (Cert. Of Blindness ma	y substitute for professional certification) (*automatic loss of license)
Chronic Lung Disease Please state FEV1 Test results Use of Portable Oxygen? Yes	O2 saturation with minimal exertion No
Cardiovascular Disease	
AHA Functional Classification (circle of	one): I II IV* (*automatic loss of license)
Arthritis (please state type, severity, a	and location)
Loss of or permanent loss of use of a li Description of functional disability	
HEALTHCARE PROVIDER MUST CHECK	K ONE:
In my professional opinion and to a reasonable	degree of medical certainty:
operation of a motor vehicle. ☐ The person applying for this permit is NOT	condition of which I am aware, <i>WILL NOT IMPAIR</i> the safe T medically qualified to operate a motor vehicle safely. If such severity as to require a <i>COMPETENCY ROAD TEST</i> .
CERTIFICATION: (Please Print)	
Healthcare Providers Name	Title Mass Board of Registration. #
	Mass Doald of Registration. π
Address	
Telephone Number	
Healthcare Providers Signature	Date